

**PATIENT PROTECTION AND AFFORDABLE CARE ACT
TITLE X - STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE
FOR ALL AMERICANS, SUBTITLE B, PART III, SECTION 10221:
INDIAN HEALTH CARE IMPROVEMENT ACT
SECTION-BY-SECTION SUMMARY**

On March 23rd 2010, President Obama signed into law new health insurance reform legislation - H.R.3590, the Patient Protection and Affordable Care Act (PPACA). This new law will impact how Native Americans access health care services and also creates new opportunities for advancements in the Indian health system. The PPACA included a permanent reauthorization of the Indian Health Care Improvement Act.

The goal of the health insurance reform legislation, PPACA, is to expand health care coverage to 32 million more Americans. The health insurance reform expands health insurance coverage to Americans, reimbursements to health care providers, enhances patient protections, boosts recruitment and retention of providers (especially primary care), and provides grants for numerous health care programs such as services for prevention, health disparities, improved access. Native Americans are eligible to participate in the health care reforms, including the expansions to Medicaid and the Insurance Exchanges, and Indian health programs are eligible to take advantage of reforms for health care providers, including grant programs. Therefore PPACA will increase Native Americans' access to health care coverage, beyond the Indian Health Service (IHS), and grant programs and other opportunities to improve the Indian health system.

Below is first a detailed section by section of the Indian Health Care Improvement Act. Following the section by section, are descriptions of provisions in PPACA which directly apply to Native Americans, tribes or Indian health programs and also those health insurance reform provisions which will likely have a significant impact on IHS patients and the entire Indian health system in the coming years.

INDIAN HEALTH CARE IMPROVEMENT REAUTHORIZATION AND EXTENSION

S.1790, the Indian Health Care Improvement Reauthorization and Extension Act, as reported out of the Senate Committee on Indian Affairs was included in PPACA. S.1790 was a cut-and-bite bill, meaning that it only included provisions which updated the Indian Health Care Improvement Act which was already in current law, but did not restate all of current law. The section numbers below reflect the section numbers of S.1790.

The inclusion of the permanent reauthorization of the Indian Health Care Improvement Act was done by referencing S.1790, instead of including the text in its entirety within PPACA.

There were a few changes made to the reported version S.1790 with its inclusion in PPACA. These changes are represented in the section by section below.

Section 101. Reauthorization: This section permanently reauthorizes the Indian Health Care Improvement Act.

Section 102. Findings: The section provides a description of the Federal Government's trust responsibility to provide health care to Native Americans.

Section 103. Declaration: The Declaration provision reaffirms that the national Indian health policy is to assure the highest possible health status for Native Americans, and articulates the policy of ensuring maximum Indian participation in the direction of health care services.

Section 104. Definitions: This section provides necessary and applicable definitions of key terms used in the bill. For example, an Indian health program refers to a health program operated by a tribe or the IHS.

SUBTITLE A – Indian Health Manpower

Section 111. Community Health Aide Program. This section continues the authorization for operation of the community health aide program (CHAP) in Alaska through which non-physician practitioners are trained and certified to deliver basic health care, particularly in remote Indian communities. Building on the success of the Alaska program, this section would authorize development of CHAP programs, except for Dental Health Aide Therapists (DHAT), for tribes in the lower 48 states.

Although the Dental Health Aide Therapists program, as executed in Alaska, is not authorized for expansion in the lower 48 states, this section allows, at the tribes' election, Indian health programs and urban Indian programs to utilize mid-level dental health providers in States where it is authorized or where mid-level programs may be authorized by federal law. Furthermore, the Indian Health Service is prevented from filling vacancies for dentists with mid-level dental health providers.

Section 112. Health Professional Chronic Shortage Demonstration Program. This section emphasizes the need for more health care professionals in the Indian health system, by allowing Indian health programs to offer practical experience to medical students. Also, this section provides training and support for alternative provider types, such as community health representatives and community health aides.

Section 113. Exemption from Payment of Certain Fees. The section extends the exemption from Federal agency licensing fees available to the Public Health Service Commission Corps (including the IHS) to employees of tribal health programs and urban Indian organizations.

SUBTITLE B – Health Services

Section 121. Indian Health Care Improvement Fund: This section authorizes funds to be used for the elimination of the deficiencies in the health status and resources for tribes, backlogs in health care services, and inequities in funding for direct care and Contract Health Services (CHS) programs, and also to supplement the ability of the IHS to meet its responsibilities. A report to Congress on the current health status and resource deficiency for each IHS Service unit is required within three years.

Section 122. Catastrophic Health Emergency Fund: This section reauthorizes the existing Indian Catastrophic Health Emergency Fund (CHEF) to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses and updates the threshold of cost for CHEF to the 2000 level of \$19,000.

Section 123. Diabetes prevention, treatment, and control: The section requires the Director of IHS to determine the incidence of diabetes among Native Americans and the measures needed to prevent, treat and control this disease. To the extent that funding is available, requires IHS to work with each IHS Area Office to consult with Indian tribes and tribal organizations regarding diabetes programs, establish patient registries in Area Offices, and ensure that data collected are disseminated to other Area Offices. Also the section authorizes IHS to enhance diabetes treatment services, such as providing dialysis programs and establishing diabetes control officers.

Section 124. Other authority for provision of services; Shared Services for Long-term Care: The section authorizes the sharing of facilities and staff between IHS and tribally-operated long-term care programs. Also, provides authorization for hospice care, assisted living, long-term care and home- and community-based care.

Section 125. Reimbursement from Certain Third Parties of Costs of Health Services: Under current law, tribally operated facilities are unable to recover the cost of care provided to beneficiaries injured by a third party. IHS operated facilities are able to recover costs from liable third parties. This provision would revise current law to extend the ability to recover costs from third parties to tribally operated facilities.

Section 126. Crediting of Reimbursements: This provision provides revisions to current law for the authorization of crediting reimbursements (for services provided by a service unit of the

IHS, a tribal or urban Indian organization program) and identifies Federal laws which authorize these reimbursements.

Section 127. Behavioral Health Training and Community Education Programs: This provision extends the training and community education programs and study authorized in current law for mental health to all behavioral health services.

Section 128. Cancer Screening: This section authorizes cancer screenings beyond mammographies, the only type of cancer screening which was authorized under current law.

Section 129. Patient Travel Costs: This section continues the authority for funds to be used for travel costs of patients receiving health care services provided either directly by IHS, under contract health care, or through a tribal health program. In addition, this section authorizes funds for qualified escorts and transportation by private vehicle (where no other transportation is available), specially equipped vehicle, ambulance or by other means required when air or motor vehicle transport is not available.

Section 130. Epidemiology Centers: This section not only continues the authority for operation and funding of tribal epidemiology centers, but also gives the centers status as public health authorities for purposes of the Health Insurance Portability and Accountability Act of 1996 in order for them to access data needed to perform their mission.

Section 131. Indian Youth Grant Program: This section continues the authority for the Director of IHS to provide grants to tribes, tribal organizations and urban Indian organizations for innovative mental and physical disease prevention and health promotion and treatment programs for Indian youth.

Section 132. American Indians Into Psychology Program: This provision expands the American Indians Into Psychology Program by requiring the IHS to provide grants to colleges and universities for developing and maintaining Indian psychology career recruitment programs. Before passage of this legislation, the authorization only allowed for grants to up to 3 schools. This section increases the number of grants to up to 9 schools for a maximum of \$300,000 for each school.

Section 133. Prevention, Control, and Elimination of Communicable and Infectious Diseases: This section amends current law by (1) expanding the communicable diseases from tuberculosis to other communicable and infectious diseases; (2) encouraging, rather than requiring, that entities funded under this section coordinate with the Centers for Disease Control and state and local health agencies; and (3) eliminating provisions of current law which would

reduce the grant amount for expenses incurred by the federal government or for supplies or equipment furnished to the grant recipient.

Section 134. Methods to increase clinician recruitment and retention: This section exempts health care professionals employed by a tribally operated health program from state licensing requirements if the professional is licensed in any state, as is the case with IHS health care professionals. The requirement for licensure in any state (not necessarily the state of practice) has been in place for health care professionals working for the IHS (and other federal agencies such as the Veteran's Administration).

This section also authorizes the IHS to provide assistance with licensing, board or certification examinations and technical assistance for fulfilling service obligations to Indian health scholarship/stipend recipients and health professionals and to provide programs for health professionals employed in an Indian health program for professional consultation and refresher training courses. These programs will assist in the recruitment of health care providers in the Indian health system.

Section 135. Liability for Payment: This section of the Indian Health Care Improvement Act prevents a patient, who receives authorized CHS care, from being liable for any charges or costs associated with those authorized services. The section also requires the Secretary of the Department of Health and Human Services (HHS) to notify the contract care provider and the patient who receives such services that the patient is not liable within five days of the receipt of claim. The section changes current law to include the patient protection of preventing further recourse against a patient who receives authorized CHS care when IHS does not pay the claim in a timely manner.

Section 136. Office of Indian Men's and Indian Women's Health: The section establishes within the IHS an Office of Indian Men's Health to complement the Office of Indian Women's Health that exists in current law.

Section 137. Contract Health Service Administration and Disbursement Formula: In a later section, S.1790 directs the Government Accountability Office (GAO) to conduct an investigation of CHS program. The investigation must include a report on the adequacy of funding levels of CHS, any inequities in the distribution of the CHS funds, and recommendations to address any issues identified. This section directs the Secretary of HHS, at completion of this report, to consult with tribes regarding CHS funding and the distribution of those funds. If, after those the study and tribal consultation are complete, the Secretary determines that it would be appropriate to revisit the CHS formula then the section authorizes negotiated rulemaking procedures to develop a new formula.

Section 141. Health Care Facility Priority System: This section authorizes the creation of s a Health Care Facility Priority System to be developed in consultation with Indian tribes and tribal organizations for the planning, design, construction, renovation and expansion needs of the Indian Health Service (IHS) and non-IHS facilities. The section also directs the Director of IHS to nominate new projects for planning, design and construction of health facilities at least once every 3 years as well as protects the priority of certain existing construction projects that were identified in past fiscal years. Lastly, the Director of IHS is required to provide Congress with comprehensive reports on all health care facility needs in Indian Country.

Section 142. Priority of Certain Projects Protected: This section restates (exactly) a provision in section 141, which protects facilities construction projects on the current Indian Health Service priority list.

Section 143. Indian Health Care Delivery Demonstration Projects: This section authorizes the development of new health programs offering care outside of regular clinic operational hours and/or in alternative settings, including through telehealth. Also, the section allows tribes more flexibility to develop innovative demonstration projects that are “tribally driven” and health facilities to combine funds from the Federal government, third-party collections, State or local governmental agencies and/or private health care providers when participating in these demonstration projects.

Section 144. Tribal Management of Federally Owned Quarters: This section allows tribes and tribal organizations, which operate a health facility and Federally-owned quarters associated with such facility under the Indian Self-Determination and Education Assistance Act, to set rental rates and collect rents from occupants of the quarters.

Section 145. Other Funding, Equipment and Supplies for Facilities: This section allows for the transfer of funds, equipment or other supplies from any source, including federal or state agencies, to HHS for use in construction or operation of Indian health care facilities and sanitation facilities.

Section 146. Indian Country Modular Component Facilities Demonstration Program: This section requires IHS to establish a new demonstration program for construction of health care facilities using a new type of innovative construction technology, modular component construction, utilized in the private sector and other government agencies.

Section 147. Mobile Health Stations Demonstration Program: This section requires IHS to establish a demonstration program for consortia of two or more service units to access funding to purchase a mobile health station to provide specialty health care services such as dentistry,

mammography and dialysis. Mobile health stations have been successfully used in rural communities where access to a health facility or health care provider is difficult.

SUBTITLE D – Access to Health Services

Section 151. Treatment of payments under the Social Security Act health benefits programs: This section updates current law regarding collection of reimbursements from Medicare, Medicaid and CHIP by Indian health facilities, and revises the procedures which allow a tribally-operated program to directly collect such reimbursements for the services it provides.

Section 152. Purchasing health care coverage: This section authorizes tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries using appropriated health care dollars.

Section 153. Grants to and contracts with the Service, Indian tribes, tribal organizations, and urban Indian organizations: Section 153 updates current law authority for IHS to issue grants or contracts to tribes, tribal organizations and urban Indian organizations to conduct outreach to enroll eligible Indians in Social Security Act health benefit programs.

Section 154. Sharing arrangements with Federal Agencies: This provision authorizes IHS to enter into arrangements with the Department of Veterans Affairs and Department of Defense to share medical facilities and services. These arrangements could include IHS, tribal and tribal organization hospitals and clinics.

Section 155. Eligible Indian Veteran's services: This section establishes procedures to facilitate the provision of health services to eligible Indian veterans by the IHS and Department of Veterans Affairs. The language authorizes the use of IHS dollars (except for Contract Health Service funds) for any co-pay required for a Veteran's health care obtained through the Department of Veterans Affairs.

Section 156. Nondiscrimination under Federal health care programs: This section provides that IHS, tribal and urban Indian organization programs shall be eligible for participation in any Federal health care program to the same extent as any other provider, if the Indian program meets the generally applicable State or other requirements for participation. However, the Indian health program or urban Indian organization is not required to actually attain the State license.

Section 157. Access to Federal insurance: This provision allows a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act and an urban Indian organization carrying out a program under Title V of IHCIA to purchase coverage for its employees from the Federal Employees Health Benefits Program.

Section 158. General Exceptions: Section 158 provides that special purpose insurance products (such as those that provide compensation to a victim of a disease) are not considered a third party payer under IHICA, so that a policy holder may receive any applicable cash benefits directly for time off-work, transportation, etc.

Section 159. Navajo Nation Medicaid Agency Feasibility Study: This section requires the Secretary of HHS to conduct a study to determine the feasibility of treating the Navajo Nation as a State for Medicaid purposes. The section outlines the requirements on the considerations for the report to Congress.

SUBTITLE E – Health Services for Urban Indians

Section 161. Facilities Renovation. The provision authorizes the funds to be made available for the construction or expansion of facilities for urban Indian health programs.

Section 162. Treatment of Certain Demonstration Projects. This section makes the Tulsa Clinic and Oklahoma City Clinic demonstration projects in Oklahoma permanent and parallels the language of the Interior Appropriations Act which first contained this provision.

Section 163. Requirement to Confer with Urban Indian Organizations: This section requires IHS to confer with urban Indian organizations in carrying out certain provisions of this Act.

Section 164. Expand Program Authority for Urban Indian Organizations: Section 164 authorizes IHS to establish behavioral health or mental health training, drug abuse prevention programs, and communicable disease prevention programs for urban Indian organizations.

Section 165. Community Health Representatives: This section authorizes the establishment of a Community Health Representative (CHR) program for urban Indian organizations to train and employ Indians to provide health care services.

Section 166. Use of Federal Government and Sources of Supply; Health Information Technology: This section grants urban Indian organizations access to the federal sources of supply and authorizes the Director of IHS to make grants available to urban Indian organizations for the development, adoption and implementation of health information technology, telemedicine services development and related infrastructure.

SUBTITLE F – Organizational Improvements

Section 171. Establishment of the Indian Health Service as an Agency of the Public Health Service: This section amends current law to enhance the duties, responsibilities, and authorities of the IHS Director, including the responsibility to facilitate advocacy and promote consultation on matters relating to Indian health within HHS. The section mandates the Director of IHS to create specific management training for all IHS managers, directors and Chief Executive Officers.

Section 172. Office of Direct Service Tribes: Section 172 relocates the IHS Office of Direct Service Tribes from the program level to the immediate office of the Director for IHS.

Section 173. Nevada Area Office. This section directs the Secretary of HHS to submit a plan to Congress for the creation of a Nevada IHS Area Office, separating Indian health programs in the state of Nevada from the Phoenix Area of IHS. The section also requires Secretary of HHS to follow the IHS tribal consultation policy in development of the plan. Failure to submit a plan to Congress within one year will result in withholding of funding to the Office of the Director of IHS, which may be restored upon completion of report. Any withholding may not affect the health services provided to Indians.

SUBTITLE G – Behavioral Health Programs

Section 181. Behavioral Health Programs: This bill section rewrites IHCA Title VII to encompass the broader focus of behavioral health as compared with current law's more narrow focus on substance abuse. *The section numbers below relate to the sections of current law.*

Subtitle A—General Programs

Section 701. Definitions: This section includes the appropriate definitions for the behavioral health programs authorized under this subtitle.

Section 702. Behavioral Health Prevention and Treatment Services: This provision describes the specific authorizations for a comprehensive continuum of behavioral health care to include community-based care, detoxification, hospitalization, intensive out-patient treatment, residential treatment, transitional living, emergency shelter, case management, and diagnostic services.

Section 703. Memoranda of Agreement with the Department of Interior: This section directs the IHS to enter into a memorandum of agreement (MOA) with the Secretary of the Interior to develop a comprehensive strategy for addressing Indian alcohol and substance abuse and mental health issues.

Section 704. Comprehensive Behavioral Health Prevention and Treatment Program: This provision directs the IHS to establish comprehensive behavioral health, prevention and treatment programs for Indians.

Section 705. Mental Health Technician Program: Section 705 authorizes the establishment of a mental health technician program within IHS to train Indians as mental health technicians to provide basic community-based mental health care.

Section 706. Licensing Requirement for Mental Health Care Workers: The section details the mandatory licensing requirements for mental health workers and establishes protocols for oversight of mental health trainees.

Section 707. Indian Women Treatment Programs: Section 707 authorizes IHS grants to Indian health programs to develop and implement comprehensive behavioral health programs that specifically address the cultural, historical, social and child care needs of Indian women.

Section 708. Indian Youth Program: This section authorizes the establishment of a program for acute detoxification and treatment for Indian youth, including behavioral health services and family involvement.

Section 709. Inpatient and Community-Based Mental Health Facilities Design, Construction and Staffing: This section authorizes the establishment, in each IHS area, of not less than one inpatient mental health care facility, or equivalent, to serve Indians with behavioral health problems.

Section 710. Training and Community Education: This section instructs the Secretary of HHS to work with the Interior Secretary to develop and implement or assist Indian tribes and organizations in establishing a community education and involvement program to educate tribal leaders, judges, law enforcement personnel, and health and education boards about community behavioral health issues.

Section 711. Behavioral Health Program: This section allows IHS to make grants to Indian health programs to establish innovative community-based behavioral health services to Indians. This will be set up as a competitive grant based program.

Section 712. Fetal Alcohol Spectrum Disorders Programs: This section authorizes the establishment of a fetal alcohol spectrum disorders program to train providers to identify and treat pregnant women at high risk of birthing a child with fetal alcohol spectrum disorders and children born with alcohol related disorders.

Section 713. Child Sexual Abuse Prevention and Treatment Programs: Section 713 authorizes the establishment of a culturally appropriate program, in each IHS area, to treat victims of child abuse as well as family members and/or household members of the victim.

Section 714. Domestic and Sexual Violence Prevention and Treatment: This section authorizes the establishment of a culturally appropriate program, in each IHS area, to prevent and treat Indian victims of domestic and sexual violence as well as family members and/or household members of the victim.

Section 715. Behavioral Health Research: This section authorizes the IHS to make grants to Indian and non-Indian entities to perform research on Indian behavioral health issues, including the causes of Indian youth suicide.

Subtitle B—Indian Youth Suicide Prevention

Section 721. Findings and Purpose: The first section in Subtitle B sets out Congressional findings on the high prevalence of suicide among Indian youth and establishes a framework for addressing this critical situation.

Section 722. Definitions: Section 722 includes necessary and applicable definitions for Subtitle B, including telemental health.

Section 723. Indian Youth Telemental Health Demonstration Project: This section authorizes the IHS to carry out a demonstration project for telemental health services targeted to Indian youth suicide prevention. The demonstration project will award up to five grants, for four years each, to tribes and tribal organizations.

Section 724. Substance Abuse and Mental Health Services Administration Grants: This section enhances the provision of mental health care services for Indian youth provided through SAMHSA by removing barriers that currently prevent Indian Tribes and tribal organizations from applying for SAMHSA grants.

Section 725. Use of Predoctoral Psychology and Psychiatry Interns: This section encourages Indian tribes, tribal organizations and other mental health care providers to utilize pre-doctoral psychology and psychiatry interns. Tribal communities face extreme shortages of mental health professionals and this provision will help increase the number of patients accessing care and serve as a recruitment tool for psychologists and psychiatrists.

Section 726. Indian Youth Life Skills Development Demonstration Program: This section authorizes a demonstration grant program through the Substance Abuse and Mental Health Services Administration to provide grants to tribes and tribal organizations to provide culturally

compatible, school-based suicide prevention curriculum to strengthen the Native American teen “life skills”.

SUBTITLE H – Miscellaneous

Section 191. Confidentiality of Medical Quality Assurance Records; qualified immunity for participants: Section 191 allows for peer reviews to be conducted within Indian health programs without compromising confidentiality of medical records.

Abortion Limitation (amends section “806” of current law Indian Health Care Improvement Act): This provision was added to the Indian Health Care Improvement Act when it was incorporated into H.R.3590, the Senate health insurance reform legislation. The provision explicitly confines the Indian Health Service to the abortion-related policies in the larger health care reform bill. Since 1982, Indian health programs have been restricted by Hyde language, to prevent any federal funding being used for abortion. *This was an addition to S.1790 made in PPACA. It is section 806 of current law.*

Section 192. Arizona, North Dakota and South Dakota as Contract Health Service Delivery Areas; eligibility of California Indians. This section both continues current law authority to make Arizona a permanent contract health service delivery area and establishes a single contract health services delivery area consisting of the states of North Dakota and South Dakota. These contract health service delivery areas are for the purposes of providing contract health care services to members of Indian tribes located in those states. This section also updates the current law provision for health care services provided to California Indians.

Section 193. Methods to increase access to professionals of certain corps. This section facilitates Indian health programs’ access to National Health Service Corps personnel.

Section 194. Health Services for ineligible persons. Section 194 provides that IHS-operated and tribally-operated programs may provide health care services to non-IHS eligible beneficiaries so long as there is no diminution in services to IHS eligible beneficiaries, and makes non-beneficiaries liable for payment for such services. Those non-IHS eligible beneficiaries must pay for the health care service they receive. Also, this provision clarifies that such services are subject to terms and conditions of ISDEAA contracts and compacts, and that Federal Tort Claims Act (FTCA) coverage will apply to these services. This section was in part aimed at ensuring Indian health programs could take advantage of the new population of insured patients in this country and benefit from the reimbursements available for providing the care.

Section 195. Annual Budget Submission: Section 195 requires that dollar amounts to cover medical inflation and population growth be included as a part of the President's IHS budget submission to Congress beginning in fiscal year 2011.

Section 196. Prescription Drug Monitoring: This section directs the Secretary of HHS, in partnership with the Department of Justice to develop and conduct a prescription drug monitoring program. The program incorporates an assessment of the capability of tribal agencies to collect data and analyze prescription drug abuse, training for Indian health workers, and reports to Congress on prescription drug monitoring and abuse in tribal communities.

Section 197. Tribal Health Program Option for Cost Sharing: This section authorizes Tribal health programs operating under a Self-Governance compact to charge Native Americans for services, such as require co-pays. The provision prohibits IHS to charge Native Americans for health care services.

Section 198. Disease and Injury Prevention Report: This provision directs the Director of the IHS to issue a disease prevention report to Congress within 18 months. The report would describe and evaluate all of the IHS' ongoing disease and injury prevention activities.

Section 199. Other GAO Reports: This section requires the GAO to conduct two studies study and submit reports with recommendations to Congress. This first report required within 18 months, looks at the effectiveness of coordinating Indian health care services through Medicare, Medicaid and SCHIP, by the IHS or using funds provided by state, local or tribal governments. The section report requires the GAO to conduct a study of the CHS program, including adequacy of funding levels for the CHS program, possible inequities in the distribution of CHS funds, and recommendations to address any inequities identified.

Section 199A. Traditional Health Care Practices: This provision prohibits the Federal Tort Claims Act (FTCA) from covering traditional health care practices conducted within the Indian health care system. This means that the United States government will not be liable for any injury caused as a result of any traditional health care practices. The section does allow for the Secretary of HHS to promote traditional health care practices within the Indian health system.

Section 199B. Director of HIV/AIDS Prevention and Treatment: The Director of IHS is required to create a position for HIV/AIDS prevention and treatment within the agency, in this section. The Director will coordinate HIV/AIDS prevention and treatment activities, provide technical assistance to Indian health programs and ensure interagency coordination to facilitate the inclusion of Native Americans in research and grant opportunities. The Director is required to also submit a report to Congress on these activities once every two years.

TITLE II – AMENDMENTS TO OTHER ACTS

Section 201. Reauthorization of Native Hawaiian health care programs: This section authorizes a straight reauthorization and extension of Native Hawaiian laws until 2019.